

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036053

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4784

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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2 3878

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 35 YEARS	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7022 PERSPECT Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First IRVIN Middle ALFRED Last COCHRAN		4. DATE OF DEATH Month AUGUST Day 27 Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-16-20
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehousman		9b. KIND OF BUSINESS OR INDUSTRY EYANS	9c. AGE (last birthday) 43
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehousman		10b. KIND OF BUSINESS OR INDUSTRY EYANS	10c. BIRTHPLACE (City and state or country) Brownfield, Missouri
11. BIRTHPLACE (City and state or country) Brownfield, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William A. Cochran		13b. MOTHER'S MAIDEN NAME Nora Stark	14. NAME OF HUSBAND OR WIFE Ina B. Cochran
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) Yes WWII		16. SOCIAL SECURITY NO. 86 VA HOSPITAL OFFICAL RECORDS, K. C. MO.	
17. INFORMANT Danny Cochran (son)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Arteriolateral myocardial infarction DUE TO (c) Coronary occlusion, left anterior descending coronary PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized atherosclerosis PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. VA attended the deceased from 8-7-63 to 8-27-63 Death occurred at 7:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE OF REGISTRAR Craig L. Fischer M.D.	
22b. ADDRESS VA Hospital, K. C. Mo.		22c. DATE SIGNED 8-28-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUG. 30, 1963	23c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 8-29-63	26. REGISTRAR'S SIGNATURE Bessie Smith

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Rollie R Kessel

Licensed Embalmer No. 4690

P. O. Address Indep. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.